

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07485

## CERTIFICATE OF DEATH

07481  
07/66

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Garrett</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Garrett</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL and <b>Oakland</b>		c. LENGTH OF STAY IN lb <b>2 1/2 Yrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>XO</b> <b>Loch Lynn</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Evans Nursing Home</b>		d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>Wayman</b>	Middle <b>Close</b>	Last <b>Beckman</b>	4. DATE OF DEATH	Month <b>July</b>	Day <b>5</b>	Year <b>19 57</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>April 6, 1873</b>	9. AGE (In years last birthday) <b>84</b> yrs.	IF UNDER 1 YEAR Months <b>84</b>	IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Farm</b>		11. BIRTHPLACE (State or foreign country) <b>Garrett Co., Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Henry Beckman</b>		14. MOTHER'S MAIDEN NAME <b>Sarah Close</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT		Address	
				<b>W. Elwood Beckman, R.D.l, Oakland, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction, Auto</b> INTERVAL BETWEEN ONSET AND DEATH <b>1 hour</b>							
420.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic heart disease</b> Years (c) <b>Senility</b> Years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>M.D. 58 2nd St. Oakland, Md.</b>		20f. (City or town) <b>Oakland, Md.</b>	(County) <b>Garrett Co.</b> (State) <b>Md.</b>
21. I certify that I attended the deceased from <b>July 1, 1957</b> to <b>July 1, 1957</b> , that I last saw the deceased alive on <b>July 1, 1957</b> , and that death occurred at <b>5:15A M.</b> from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <b>58 2nd St. Oakland, Md.</b> DATE SIGNED <b>7-5-57</b>							
ACTUAL SIGNATURE <i>James H. Feaster, M.D.</i>		PHYSICIAN'S NAME (Type) <b>James H. Feaster, M.D.</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7/7/57</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Beckman Cemetery</b>		22d. LOCATION (City, town, or county) <b>Uni. S. Loch Lynn, Md.</b> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Herbert C. Leighton</i>		ADDRESS <b>Oakland, Md.</b>		24a. REC'D BY REGISTRAR <b>7/6/57</b>		24b. REGISTRAR'S SIGNATURE <i>Debra A. Brown</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-trust permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the registrar, prior to burial, cremation, or removal, and in any event within 72 hours after death.

EF 20070728-0200 00 TELUSKRAZD STAZI OMALYRAN

DURAU V. S.

JUL 11 1957

REGELIV E

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07486

## CERTIFICATE OF DEATH

07486 6

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY GARRETT MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY GARRETT	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X1 RURAL OAKLAND	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION GARRETT COUNTY MEMORIAL HOSPITAL		d. STREET ADDRESS ROUTE # 2, BOX # 9	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First MARK	Middle -	Last DILSWORTH
4. DATE OF DEATH	Month JULY		Day 16
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEB. 3rd., 1877
9. AGE (In years last birthday) 80 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired - Laborer General		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) WEST VIRGINIA		12. CITIZEN OF WHAT COUNTRY? UNITED STATES	
13. FATHER'S NAME DILSWORTH, Isaac John Timmes		14. MOTHER'S MAIDEN NAME Victoria Moreland	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? 110 (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 17. INFORMANT Address ELMER DILSWORTH RT. #2, BOX #9, OAKLAND, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 610X DUE TO <i>Uremia</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO <i>Benign prostatic hypertrophy</i> 6 mos. (c)		INTERVAL BETWEEN ONSET AND DEATH 4 mos.	
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Nat white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>7/15/57</u> , 1957, to <u>7/16</u> , 1957, that I last saw the deceased alive on <u>7/16</u> , 1957, and that death occurred at <u>9:15 P.M.</u> from the causes and on the date stated above. ACTUAL SIGNATURE <u>Joseph Alvarez</u> M.D. PHYSICIAN'S NAME (Type) JOSEPH ALVAREZ M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>7-18-1957</u>	22c. NAME OF CEMETERY OR CREMATORIAL <u>Underwood Cem.</u>
22d. LOCATION (City, town, or county) <u>Oakland, Md.</u>		(State) <u>Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Herbert C. Leighton</u>		ADDRESS <u>Oakland-Md.</u>	24a. REC'D BY REGISTRAR <u>J. L. Bowan</u> DATE <u>7/18/57</u>
24b. REGISTRAR'S SIGNATURE <u>J. L. Bowan</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

DEPARTMENT OF HEALTH - MEDICINE & NURSING

CERTIFICATE OF DEATH

BUREAU V. S.

JUL 24 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

117484

Reg. Dist. No. 166

07484

1. PLACE OF DEATH  
a. COUNTY

Garrett

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL  
and give nearest town)

Rural

Oakland

c. LENGTH OF STAY IN 1b

53 yrs.

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)

a. STATE Maryland

b. COUNTY Garrett

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Rural

x1 Oakland

d. STREET ADDRESS

1

e. IS RESIDENCE  
ON A FARM?  
YES  NO

3. NAME OF  
DECEASED  
(Type or print)

First

Middle

Last

4. DATE  
OF  
DEATH

JULY  
8

Day  
1951

Month  
Year

5. SEX

Male

6. COLOR OR RACE

White

7. MARRIED

NEVER MARRIED

8. DATE OF BIRTH

May 13, 1892

9. AGE (In years  
to birthday  
for birthdate  
in years)

75 yrs.

10. IF UNDER 1 YEAR

Months  
Days

11. IF UNDER 24 HRS.

Hours  
Min.

10a. USUAL OCCUPATION (Give kind of work done  
during most of working life, even if retired)

Farming

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

W. Va.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Daniel W. Dodge

14. MOTHER'S MAIDEN NAME

Hulda Harned

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no, or unknown)

(If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

Mrs. Artie Dodge

Address

INTERVAL BETWEEN  
ONSET AND DEATH

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a)

919.0

DUE TO

GUN SHOT WOUND OF HEAD

Conditions, if any, which  
gave rise to immediate cause  
(a), stating the underlying  
cause last.

(b)

DUE TO

ACCIDENTAL DISCHARGE OF RIFLE

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY  
PERFORMED?

YES  NO

20a. EXTERNAL CAUSE WAS  
PRIMARY  OR CONTRIBUTING

CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

22 Rifle Accidental Discharged

20c. TIME OF INJURY Month, Day, Year

6:00 p.m. 7/18 1957

20d. INJURY OCCURRED

While at work  Not while at work

20e. PLACE OF INJURY (Home, farm,  
factory, street, office bldg., etc.)

House near Oakland

20f. (City or town)

Garrett

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , and find that death resulted from: Natural causes , Accident , Suicide , Homicide , Undetermined cause .

ACTUAL  
SIGNATURE

E. J. BADINGARTNER

M.D. CHIEF MEDICAL EXAMINER

ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

DATE SIGNED  
7/16/57

EXAMINER'S  
NAME (Type)

S. J. Badingartner

22a. BURIAL, CREMATION, REMOVAL (Specify)

22b. DATE THEREOF

22c. NAME OF CEMETERY OR CREMATORIUM

22d. LOCATION (City, town, or county)

22e. (State)

23. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

24. REG'D BY REGISTRAR

DATE

24. REGISTRAR'S SIGNATURE

DATE

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your information.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill Page 1 and 2 with the registrant's name or removal.

V.S. A15ME(5)  
5M 9/55

MASSACHUSETTS STATE BOARD OF HEALTH - BOSTON  
MEDICAL DRAWINGS CERTIFICATE OF DEATH

Mass. State Hospital, Boston

BUREAU V. S.

JUL 17 1957

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07485  
7/28

07488

## CERTIFICATE OF DEATH

Reg. Dist. No.

1		M		70		I		2		2			
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.		TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it may be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the registrar, prior to burial, cremation, or removal, and in any event within 72 hours after death.											
1. PLACE OF DEATH a. COUNTY <b>GARRETT COUNTY</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b>		b. COUNTY <b>MARYLAND. Garr. Co.</b>		3. NAME OF DECEASED (Type or print) <b>JAMES</b>		First      Middle      Last		4. DATE OF DEATH Month      Day      Year <b>JULY 21, 1957</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oakland</b>		c. LENGTH OF STAY IN 1b <b>12 DAYS</b>		d. STREET ADDRESS <b>OAKLAND, MARYLAND</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>GARRETT COUNTY MEMORIAL HOSPITAL</b>		5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. B. DATE OF BIRTH <b>5/11/85</b>		9. AGE (In years lost birthday) <b>72 yrs.</b>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>UNEMPLOYED</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>[REDACTED]</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>JOHN FAZENBAKER</b>		14. MOTHER'S MAIDEN NAME <b>RITTINGER, SUZANNE</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>442X</b>		16. SOCIAL SECURITY NO. <b>220-10-2880</b>		17. INFORMANT <b>WIFE ANNIE, FAZENBAKER</b>		Address <b>ACCIDENT, MARYLAND</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Paritonitis + Pelvic Abscess</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b>									
(b) DUE TO Paracentesis for Ascites		(c) DUE TO Ascites due to Cardio Renal Failure		4 weeks 1 year									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Atherosclerosis Cardiovascular Disease</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20d. INJURY OCCURRED White Not white at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)									
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED White Not white at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)									
21. I certify that I attended the deceased from <b>March 10, 1957</b> to <b>July 21, 1957</b> , that I last saw the deceased alive on <b>July 20, 1957</b> , and that death occurred at <b>7:55 AM</b> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>77 Oak Street, Oakland, Md.</b>		DATE SIGNED <b>July 21, 1957</b>									
ACTUAL SIGNATURE <b>Herbert F. Leighton M.D.</b>		PHYSICIAN'S NAME (Type) <b>HERBERT LEIGHTON M.D.</b>		OAKLAND, MARYLAND									
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>7/23/57</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>BE</b>		22d. LOCATION (City, town, or county) <b>GARRETT CO MD</b>		(State)					
23. FUNERAL DIRECTOR'S SIGNATURE <b>Don J Newman Grantsville, Md</b>		ADDRESS <b>[REDACTED]</b>		24a. REC'D. BY REGISTRAR <b>Julia Mowen Jr</b>		24b. REGISTRAR'S SIGNATURE <b>[REDACTED]</b>		DATE <b>7/27/57</b>					
VS A15 (4) 15M 9/55													

DEPARTMENT OF STATE DOCUMENTS DEATH - BALTIMORE 18

CERTIFICATE OF DEATH

2452

MARYLAND

BUREAU V.

JUL 31 1957

RECEIVED

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-5 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07486

## 07489 CERTIFICATE OF DEATH

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN		MARYLAND LENGTH OF STAY (in this place)		STATE CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN		COUNTY CITY (If rural give location) STREET ADDRESS	
GARRETT JENNINGS MD		LIFE		MD JENNINGS, MD		GARRETT	
HOSPITAL OR INSTITUTION OR STREET ADDRESS							
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b>			
(First) NORMAN (Middle) (Last) HOOVER				JULY 29 1957			
5. SEX M	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) WIDOWED	8. DATE OF BIRTH Aug. 26. 1863	9. AGE last birthday 93	IF UNDER 1 YEAR		IF UNDER 24 HRS.
				93 yrs.	Months	Deys	Hours Min.
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED				11. BIRTHPLACE (State or foreign country) GARRETT Co. MD			
13. FATHER'S NAME CARLILE HOOVER				14. MOTHER'S MAIDEN NAME ROSANNA DURST			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)				16. SOCIAL SECURITY NO. None			
(If Yes, give war or dates of service)				17. INFORMANT & ADDRESS HARRY HOOVER, GRANTSVILLE, MD			
<b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>							
420.0 IMMEDIATE CAUSE (A) Complete heart block. ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, (B) Cystic sclerotic heart disease GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
INTERVAL BETWEEN ONSET AND DEATH 1 yr. 20 yrs.							
<b>II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
19a. DATE OF OPERATION None		19b. MAJOR FINDINGS OF OPERATION 4330		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. at work		21e. INJURY OCCURRED While Not while at work at work		21f. HOW DID INJURY OCCUR?			
<b>22. I hereby certify that I attended the deceased from Aug. 1, 1956, to July 29, 1957, that I last saw the deceased alive on July 27, 1957, and that death occurred at 10:45 A.M. from the causes and on the date stated above.</b>							
SIGNATURE G. Paige Strong M.D. ADDRESS (Street, city, town, state) Salisbury, Penna. DATE SIGNED 7/30/57							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 7/31/57		NAME OF CEMETERY OR CREMATORIAL GRANTSVILLE		LOCATION (City, town, or county) GRANTSVILLE, GARRETT Co. MD (State)	
24. REC'D BY REGISTRAR AUG 2 '57		REGISTRAR'S SIGNATURE Ae. Leach		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Donald J. Newman, Grantsville, MD			
DATE							

THE FEDERAL BUREAU OF INVESTIGATION  
U. S. DEPARTMENT OF JUSTICE

U. S. CERTIFICATE OF DEATH

RECEIVED  
DEPT. OF JUSTICE  
FEB 2 1957

STAN  
100

SEARCHED	INDEXED
SERIALIZED	FILED
FEB 2 1957	
FBI - WASHINGTON	

BUREAU V. S.

AUG 2 1957

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07487  
966

07499

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Garrett</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Virginia</b>		b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oakland</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Aylett</b>		d. STREET ADDRESS <i>83 X-3</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Week's Nursing Home</b>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Walter Weir</b>		First	Middle	Last	4. DATE OF DEATH <b>Pollard</b>	Month <b>July</b>	Day <b>9</b>	Year <b>1957</b>	
S. SEX <b>Male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></b>	9. AGE (In years lost birthday) <b>March 15, 1871</b>	86 yrs.	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b>	Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired business</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Aylett, Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>			
13. FATHER'S NAME <b>Edward Spottswood Pollard</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Walter W. Pollard, Jr., Hagerstown, Md.</b>		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>600.0</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO (b) DUE TO (c)		<b>Pulmonary edema</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 hours</b>			
				<b>Congestive heart failure</b>		<b>8 hours</b>			
				<b>Pyelonephritis + Cystitis</b>		<b>2 weeks</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>422. Vascular sclerosis Cardio vascular disease</b>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Doy	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <b>77 Oak Street, Oakland, Md.</b>	(County) <b>7/10/57</b>	(State)		
21. I certify that I attended the deceased from <b>June 29, 1957</b> , to <b>July 7, 1957</b> , that I last saw the deceased alive on <b>July 6, 1957</b> , and that death occurred at <b>10:20 A.M.</b> , from the causes and on the date stated above.									
ADDRESS (Street, city or town, state) <b>77 Oak Street, Oakland, Md.</b>									
DATE SIGNED <b>7/10/57</b>									
ACTUAL SIGNATURE <b>Herbert H. Leighton</b>									
PHYSICIAN'S NAME (Type) <b>Herbert H. Leighton</b>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial 7/11/57</b>	22b. DATE THEREOF <b>7/11/57</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Soudoun Park</b>		22d. LOCATION (City, town, or county) <b>Baltimore Maryland</b>		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Herbert C. Leighton, Oakland, Md.</b>		ADDRESS <b>7/10/57</b>		24d. REC'D. BY REGISTRAR <b>Jules A. Rowan</b>	24e. REGISTRAR'S SIGNATURE				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MISSOURI STATE DEPARTMENT OF HEALTH - SALTWATER

## CERTIFICATE OF DEATH

BUREAU V. S

JUL 17 1957

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07488

## CERTIFICATE OF DEATH

Reg. Dist. No. 172

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bolt copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

<b>1. PLACE OF DEATH</b>		<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>	
COUNTY CITY (If outside corporate limits, write RURAL OR end give nearest town) TOWN RURAL SWANTON	MARYLAND LENGTH OF STAY (in this place) 73 YRS.	STATE MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural- SWANTON	COUNTY GARRETT STREET ADDRESS (If rural give location) R#1- MT. ZION COMMUNITY
<b>3. NAME OF DECEASED</b> (First) WILLIAM (Middle) HENRY (Last) SHARPLESS		<b>4. DATE (Month) (Day) (Year)</b> OF DEATH JULY 5, 1957	
5. SEX MALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, SINGLE	8. DATE OF BIRTH MAY 14, 1884
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER		10b. KIND OF BUSINESS OR INDUSTRY OWN FARM	
11. BIRTHPLACE (State or foreign country) MT. ZION, GARRETT CO, MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME FRANCIS REASON SHARPLESS		14. MOTHER'S MAIDEN NAME ELIZABETH FULMER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? NO		16. SOCIAL SECURITY NO. 212-38-6581	
17. INFORMANT & ADDRESS Bessie Sharpless, R#1, Swanton, Md.			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>			
420.0 IMMEDIATE CAUSE (A) Myocardial Infarction, A-1E ANTECEDENT CAUSE(S) DUE TO Arteriosclerotic vascular disease DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (B) DUE TO Arteriosclerosis, heart disease STATING UNDERLYING CAUSE LAST (C) Myocardial infarction			
INTERVAL BETWEEN ONSET AND DEATH First week 2 yrs. 2 yrs. 7 yrs. 8 weeks.			
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>			
19a. DATE OF OPERATION 433.1		19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <input type="checkbox"/> (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) 21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from alive on July 19, 1957, to July 2, 1957, and that death occurred at 5 A.M., from the causes and on the date stated above. SIGNATURE W. Jester M.D. ADDRESS (Street, city, town, state) 58 1/2 St. Orland DATE SIGNED 7-5-57			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 7/3/57	
NAME OF CEMETERY OR CREMATORIAL Mt. Zion Cemetery		LOCATION (City, town, or county) R#1, Swanton, Md. (State)	
24. REC'D BY REGISTRAR DATE 7/8/57		REGISTRAR'S SIGNATURE Alice Barnet	
25. FUNERAL DIRECTOR'S SIGNATURE O. J. Sharpless		ADDRESS Blaine, W. Va.	



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 7, 11, 12, 13, 14 Film G217 7-15-57 et

07481  
90 766

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE	
<b>GARRETT Co MARYLAND</b>		<b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OAKLAND</b>		c. LENGTH OF STAY IN 1b <b>XO OAKLAND</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>CUPPETT NURSING HOME</b>		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>DANIEL</b>		First	Middle
4. DATE OF DEATH <b>V-LADICH</b>		Month	Day Year
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <b>Unknown</b>
8. DATE OF BIRTH <b>MAY - 1883</b>		9. AGE (In years lost birthday) <b>84 yrs.</b>	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED MINER.</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Unknown</b>		12. CITIZEN OF WHAT COUNTRY? <b>??</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>232-09-2184</b>	
17. INFORMANT		Address <b>CUPPETT Nursing Home OAKLAND MD</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>434.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) <b>241X Bronchial Asthma</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Dec 2nd</b> , 1956, to <b>July 1</b> , 1957, that I last saw the deceased alive on <b>July 1</b> , 1957, and that death occurred at <b>85 Cedar St</b> , M, from the causes and on the date stated above. ACTUAL SIGNATURE <b>E.P. Gartner</b> M.D. ADDRESS (Street, city or town, state) PHYSICIAN'S NAME (Type) <b>E.P. Gartner</b> DATE SIGNED <b>7/2/57</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>JULY-3-1957</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>OAKLAND CEMETERY</b>
22d. LOCATION (City, town, or county) <b>OAKLAND</b>		(State) <b>MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Emroy Bolden</b>		ADDRESS <b>OAKLAND MD</b>	24a. REC'D BY REGISTRAR DATE <b>7/6/57</b>
			24b. REGISTRAR'S SIGNATURE <b>Julia Rowans</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

18

CERTIFICATE OF DEATH

BUREAU V. S.  
RECEIVED  
JUL 11 1957

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07490

07493

## CERTIFICATE OF DEATH

Reg. Dist. No. 163

1. PLACE OF DEATH a. COUNTY Garrett		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md.		b. COUNTY Garrett	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Bloomington		c. LENGTH OF STAY IN 1b 25 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X / Rural Bloomington			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1 mi. W. Bloomington				d. STREET ADDRESS 1 mi. W. Bloomington		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Olavin	Middle John	Last Warnick	4. DATE OF DEATH July	Month 3	Day 1957	Year
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH July 25, 1884	9. AGE (In years lost birthday) 72 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Paper Mill		11. BIRTHPLACE (State or foreign country) Bloomington, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Aaron M. T. Warnick		14. MOTHER'S MAIDEN NAME Katherine Barnard					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 217-01-9794		17. INFORMANT Mrs. Herbert Barnard, Swanton, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		Coronary occlusion, infarction, (b) coronary heart disease (c) arteriosclerotic cardiovascular		INTERVAL BETWEEN ONSET AND DEATH 2 days	
DUE TO		DUE TO					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 422.1						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Feb 21, 1957, to July 3, 1957, that I last saw the deceased alive on June 6, 1957, and that death occurred at 145 P.M., from the causes and on the date stated above. ACTUAL SIGNATURE Mildred E. Sleeley M.D. ADDRESS (Street, city or town, state) PHYSICIAN'S NAME (Type)						DATE SIGNED 7-5-57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/6/57		22c. NAME OF CEMETERY OR CREMATORIUM Turner Cem		22d. LOCATION (City, town, or county) Garrett County, Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE El Boral		ADDRESS Westernport, Md.		24a. REC'D BY REGISTRAR DATE 7-6-57		24b. REGISTRAR'S SIGNATURE Dorothy Battison	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## CERTIFICATE OF DEATH

DECEASED'S NAME	AGE	SEX	CAUSE OF DEATH
EDWARD J. KELLY	60	MALE	HEART DISEASE
ADDRESS	STREET	CITY	STATE
1015 N. 10th Street	10th Street	Milwaukee	Wisconsin
NAME AND ADDRESS OF DOCTOR	NAME AND ADDRESS OF FUNERAL DIRECTOR		
Dr. John J. Kelly, 1015 N. 10th Street	John J. Kelly, 1015 N. 10th Street		
RELATIONSHIP TO DECEASED	RELATIONSHIP TO DECEASED		
Son	Daughter		
NAME AND ADDRESS OF PERSON FILING CERTIFICATE	NAME AND ADDRESS OF PERSON FILING CERTIFICATE		
John J. Kelly, 1015 N. 10th Street	John J. Kelly, 1015 N. 10th Street		
DATE OF DEATH	TIME OF DEATH		
July 8, 1957	12:00 P.M.		
RECEIVED			
FBI - MILWAUKEE			
JUL 8 1957			

BUREAU V. S

JUL 8 1957

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film 0288-5-57 et

07491  
0766

07494

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>GARRETT</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OAKLAND</b>	c. LENGTH OF STAY IN 1b RURAL and give nearest town	b. COUNTY <b>GARRETT</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OAKLAND</b>
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>WEEKS NURSING HOME</b>	e. STREET ADDRESS <b>X2 OAKLAND</b>	f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	MD
3. NAME OF DECEASED (Type or print) <b>ESTELLE</b>	First <b>MAE</b>	Middle <b>WINCHELL</b>	4. DATE OF DEATH <b>JULY - 22 1957</b>
S. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>AUG - 1 - 1863</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>WoodsFIELD OHIO</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>
13. FATHER'S NAME <b>JOHN DEVORE</b>	14. MOTHER'S MAIDEN NAME <b>MARY GRAY</b>	Address <b>WM. O. BITZER MC LAKE PARK MD.</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT <b>WM. O. BITZER</b>	INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. <b>Arteriosclerotic Cardiovascular disease</b>		(b) <b>Cerebral Vascular accident</b> DUE TO <b>10 years</b>	
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED: (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>77 Oak Street, Oakland, Md.</b>	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>July 15, 1957</b> to <b>July 22, 1957</b> that I last saw the deceased alive on <b>July 18, 1957</b> , and that death occurred at <b>12:30 AM</b> , from the causes and on the date stated above. ACTUAL SIGNATURE <b>Herbert H. Leighton, M.D.</b> ADDRESS (Street, city or town, state) <b>77 Oak Street, Oakland, Md.</b> DATE SIGNED <b>July 22, 1957</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>JULY-23-1957</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>WOODSFIELD CEMETERY</b>	22d. LOCATION (City, town, or county) <b>WOODSFIELD OHIO</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Emory Bolden</b>	ADDRESS <b>OAKLAND MD</b>	24a. REC'D BY REGISTRAR <b>Julie A. Brown</b>	24b. REGISTRAR'S SIGNATURE <b>7/22/57</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 &amp; 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MISSOURI STATE DEPARTMENT OF HEALTH - BALTIMORE 18

CERTIFICATE OF DEATH

DEATH  
REGISTRATION  
FORM

BUREAU Y. S.

JUL 24 1957

RECEIVED

**INSTRUCTIONS**

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The hospital copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07492

**CERTIFICATE OF DEATH**

Reg. Dist. No.....

**1. PLACE OF DEATH**

COUNTY

GARRETT

CITY (If outside corporate limits, write RURAL  
OR end give nearest town)

TOWN GRANTSVILLE, MD

HOSPITAL OR  
INSTITUTION OR  
STREET ADDRESS

MARYLAND

LENGTH OF STAY  
(in this place)

12 yrs.

**2. USUAL RESIDENCE (HOME) OF DECEASED**

STATE

MARYLAND

CITY (If outside corporate limits, write RURAL and give nearest town)

TOWN GRANTSVILLE, MD

STREET  
ADDRESS

(If rural give location)

**3. NAME OF  
DECEASED  
(Type or Print)**(First)  
Roy(Middle)  
HENRY(Last)  
ZEHNER**4. DATE  
OF  
DEATH**

July 7

1957

IF UNDER 1 YEAR

Months

Days

Hours

Min.

5. SEX

M

6. COLOR OR  
RACE

W

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED,  
(Specify)

MARRIED

8. DATE OF BIRTH

MAY 25, 1901

9. AGE last birthday

56 yrs.

10e. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if  
retired)

INNKEEPER

10b. KIND OF BUSINESS  
OR INDUSTRY

INN

11. BIRTHPLACE (State or foreign country)

GRANTSVILLE, MD

12. CITIZEN OF WHAT  
COUNTRY?

U.S.A

13. FATHER'S NAME

John Zehner

14. MOTHER'S MAIDEN NAME

Sadie Bonig

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.

169-01-6749

17. INFORMANT &amp; ADDRESS

Mrs. Liza Zehner, Grantsville

**I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH**

420.1 IMMEDIATE CAUSE (A)

Coronary occlusion

INTERVAL BETWEEN  
ONSET AND DEATH

ANTECEDENT CAUSE(S) DUE TO

atherosclerosis

1 hr.

DISEASES OR CONDITIONS, IF ANY, (B)  
GIVING RISE TO THE ABOVE CAUSE  
STATING UNDERLYING CAUSE LAST. DUE TO

3 yr.

(C)

**II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING DEATH.**

Cushing

581.0

19e. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY  
YES  NO 

(State)

21e. ACCIDENT WAS UNDERLYING   
OR CONTRIBUTING  CAUSE OF DEATH  
(If either, NOTIFY MEDICAL EXAMINER)21b. PLACE (Home, farm, factory,  
OF INJURY street, office bldg., etc.)

21c. WHERE DID INJURY OCCUR? (City or town)

(County)

(State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)

21e. INJURY OCCURRED  
While  Not while   
at work  at work 

21f. HOW DID INJURY OCCUR?

M. /

22. I hereby certify that I attended the deceased from July 7, 1957, to July 7, 1957, that I last saw the deceased alive on July 7, 1957, and that death occurred at 5 P.M. from the causes and on the date stated above.  
SIGNATURE *Rex Lumby Jr. M.D.* ADDRESS *Maryland Pa* DATE SIGNED *7/9/57*23. BURIAL, CREMATION,  
REMOVAL (SPECIFY)

BURIAL

DATE THEREOF

7/10/57

NAME OF CEMETERY OR CREMATORI

GRANTSVILLE

LOCATION (City, town, or county)

GRANTSVILLE, GARRETT CO, MD

(State)

24. REC'D BY REGISTRAR

REGISTRAR'S SIGNATURE

DATE JUL 15 1957

25. FUNERAL DIRECTOR'S SIGNATURE

Donald J. Newman, Hanover, Md.

ADDRESS

Chrysanthemum (Chrysanthemum)

TELEGRAMS

1975.01.01 (1975.01.01)

BUREAU V. 5

JUL 15 1957

DECEMBER

347C